# **THIS TESTIMONY IS EMBARGOED UNTIL 2:00 PM MAY 12, 2011**


Testimony of Dana Gelb Safran, Sc.D
Senior Vice President
Blue Cross Blue Shield of Massachusetts
Innovative Delivery and Physician Payment System Reform Efforts
May 12, 2011

Thank you, Mr. Chairman, Congressman Stark and Members of the Committee.
I am Dana Safran, Senior Vice President for Performance Measurement and Improvement at Blue Cross Blue Shield of Massachusetts ("BCBSMA") and I thank you for the opportunity to discuss our work towards realizing a vision of safe, effective, affordable, patient-centered health care.

Blue Cross Blue Shield of Massachusetts is one of 39 locally based, community operated Blue Cross and Blue Shield Plans that collectively provide health benefits to nearly 98 million Americans and contract with hospitals and physicians in every U.S. zip code. All Blue Plans share a commitment to transitioning from a payment system based on fee-for-service design – which rewards volume and intensity of care -- to one that pays based on quality, safety, and value.

At BCBSMA, our highest priority is to make quality health care affordable for individuals, families and employers who have made us the health plan of choice in Massachusetts. Our promise and vision guide our efforts to create greater value for our members and employers. Founded in 1937 by a group of community-minded business leaders, BCBSMA is the leading private health plan in the Commonwealth—a not-for-profit company with a proud history of community and health care leadership.

As the Committee considers the important issue of physician payment, and specifically, the SGR, I am pleased to have this opportunity to share a model that has taken hold in Massachusetts. The payment reform efforts of BCBSMA that I will describe to you today, and early results of this work, suggest that it may indeed be necessary to think beyond physician payment to overall system payment in order to realize the goal of "sustainable growth." This holistic view of payment may also be necessary to reduce the fragmentation of care that we all recognize as a key failing of our current system. This fragmentation is, almost certainly, a by-product of payment models that contemplate physician payment and institutional payment separately.

In Massachusetts, as in the rest of the nation, the unrelenting rise of health care spending imposes an unsustainable burden on the economy and on individual consumers. In 2007, BCBSMA recognized that to fundamental changes in provider payment and incentives would be required to address medical cost trends. With an annual medical spend of approximately $13 Billion in claims, we sought to develop a model that would achieve two goals: significantly improve the quality, safety and outcomes of care; and significantly slow the rate of growth on that $13 Billion.

Developed in 2007 and launched in 2009, BCBSMA's Alternative Quality Contract (AQC), was our effort to advance these twin goals. Broadly stated, the AQC combines the financial incentives of a global budget as the basis for provider payment, very modest annual inflation rates over a 5-year contract period, and robust performance-based incentives on a broad set of quality and outcome measures. The AQC is providing evidence that improvements in both health care quality and spending are achievable through a payment model that establishes provider accountability for quality, outcomes and costs. To our knowledge, BCBSMA's AQC is the only payer-led initiative that has stimulated the formation of multiple accountable care organizations within a single market. Approximately 40% of our provider network has contracted under the AQC model. Continued significant growth, with additional contracts, is expected over the next many months.

**AQC: History**

In 2007, the company evaluated how to achieve the twin goals of significantly improving quality and outcomes while significantly slowing the rate of health care spending growth. The challenge before BCBSMA was to create a payment model that would align financial goals with clinical goals, linking payment to quality, outcomes and the careful use of health care resources.

A team of physicians, finance experts, and measurement scientists worked to develop a contract model that would give hospitals and physicians meaningful incentives to improve the quality and outcomes of care while also carefully stewarding overall health care spending. BCBSMA tested the concept with key hospital and physician leaders, local and national policy experts, employers, and other health care purchasers throughout the development process, and used that feedback and input to finalize the model.

What resulted is the *Alternative Quality Contract*, an innovative global payment model that uses a budget based methodology, which combines a fixed population-based budget (adjusted annually for health status and inflation) with substantial incentive payments for performance on a broad set of clinically important, nationally accepted measures of quality, outcomes, and patient care experiences.

**AQC: The Cornerstones**

The Alternative Quality Contract includes several key components that distinguish it from our traditional contracts and that are designed to enable the provider organizations to succeed at significantly improving quality and outcomes while moderating costs and spending growth.

- **Integration Across Continuum of Care**

A provider organization that enters an AQC contract agrees to accept accountability for the full continuum of care provided to their patients – from pre-natal care to end-of-life care, and everything in-between. This does not mean that the provider organization itself must be capable of providing every aspect of care, but they must agree to be accountable for both the cost and

quality of care provided to their patients, regardless of where it is provided. The only stipulation related to organizational structure in the AQC is that the provider organization must include sufficient primary care physicians to account for at least 5,000 our HMO or POS enrollees.

The very essence of the AQC is the important role of the primary care physician (PCP) as the center of a patient's care. The decision to forego a prescriptive approach to AQC organizational structure was made as we recognized that it was premature to know which structure or organizational features were truly required to be successful under a model requiring accountability for cost and quality. As it has unfolded, the range of organizational structures among AQC groups is extremely varied – including, at one end of the continuum, an AQC organization that includes only primary care physicians and at the other end of the continuum, a large multispecialty physician group with a history and roots as a staff-model HMO (that is, as much like Kaiser as anything we have in Massachusetts). In between are several physician organizations of varying size and scope, some including a broad range of specialist physicians, others not; some including a hospital as part of their contract and others not; almost all including a very large number of practices that are small or solo physicians tied together through an infrastructure and leadership that work to enable their success under the AQC model.

Regardless of the organizational structure and scope, each and every organization is accountable for the full continuum of care and for the total cost and quality of care received by their patient population. They do this through relationships that expand well beyond the confines of the providers that are party to their AQC contract. Importantly, as I will detail later, every one of these organizations is achieving substantial success – both on quality and on managing overall medical spending. This proves an important lesson in terms of the value of a payment reform model serving as the impetus for delivery system reform, but the importance of allowing those delivery system reforms to take shape in response to the new payment incentives.

- **Sustained Partnership (Five-Year Agreement)**

The AQC arrangement is a five-year agreement that encourages providers to invest in long-term, lasting improvement initiatives. It also establishes a new kind of partnership between the health plan and the organization that moves away from the sometimes adversarial relationship, which is focused on ongoing contract negotiations, and toward a more collegial partnership, which is focused on and committed to each other's success. These 5-year contracts are significantly longer that BCBSMA traditional contracts, which are typically 3-years for a hospital and 1- 3 years for physicians. The 5-year arrangement was viewed as important because we recognized that success under this model would require provider organizations to make significant changes in care processes, staffing and infrastructure, and we did not want either the provider or Blue Cross to be concerned by a next contract negotiation looming 6 or 12 months out.

- **Global Budget Financial Structure with Performance Incentives and Savings Opportunities**

BCBSMA establishes a global budget for AQC provider organizations to cover all services and costs. The contract model is designed to include inpatient, outpatient, pharmacy, behavioral health, and other costs and services associated with each of their BCBSMA patients. The initial global budget is based on historical health care cost expenditure levels. In this way, providers are assured that their starting budgets contain sufficient funds to care for their patient population – but importantly, the provider now has important incentives to consider how best to use those funds in

service of the best quality, highest value care for each and every patient. If the AQC organization achieves savings on its budget, the organization retains all or some of those savings. If the organization outspends its budget, the organization is responsible for all or some of that deficit. There are numerous protections to guard against excessive or unfair financial risk to providers, but the AQC model creates a very real set of incentives for provider organizations to be careful steward of health care dollars. Budgets are adjusted throughout the 5-year contract to reflect changes in the health status of the provider's BCBSMA population. Since the AQC's global budget and annual inflation rates are set at the outset of the agreement for a five year period, the model brings both predictability and stability to annual health care cost increases, a significant benefit to the purchasers of health care, including consumers, employers and government.

- **Performance Measures**

Central to the AQC model is it's a set of significant financial incentives tied to performance on a broad portfolio of quality and outcome measures. As described elsewhere,[1] the model includes 64 nationally accepted, clinically important measures of hospital and ambulatory quality that, collectively, support the vision of safe, affordable, effective, patient-centered care. The accountability for performance on this broad set of quality and outcome measures, and the significant financial incentives associated with this, serve as an extremely important backstop against any impulse toward "underuse" or stinting that might otherwise be a concern under a global budget model.

BCBSMA evaluates AQC groups' performance on the quality measures in terms of performance targets ("gates") ranging from 1 to 5. For each measure, Gate 1 is set at a score that represents the beginning of performance considered to be good enough to merit some financial reward. Gate 5 is an empirically-derived score for each measure that represents the best that can be reliably achieved in a patient population. By presenting a range of targets that represent "good to great" performance, the AQC model incentivizes both performance excellence and continuous performance improvement. And through use of absolute performance targets that are fixed over the course of the contract and identical for every provider that enters the contract in that year, the model enables organizations to plan their resources in a way that will allow for continuous improvement toward Gate 5 performance over the course of the contract.

One of the most important aspects of the measure set is that it includes significant accountability for health outcomes – not just for health care processes. To our knowledge, the AQC is the first contract that required providers to assume responsibility for the outcomes achieved through their care – not solely for the care delivered in the four walls of the care setting. The importance of this feature cannot be overstated.

- **Data Support**

In order to succeed under the AQC model, BCBSMA understands that physicians need both clinical and financial data to help them identify opportunities for both efficiency and quality. Thus, with the launch of the AQC in 2009, BCBSMA established an internal team dedicated to supporting AQC groups' ability to implement timely medical management, and to continuously improve quality and efficiency. The AQC Support program is extended to all AQC organizations and includes a

[1] M. E. Chernew, R. E. Mechanic, B. E. Landon and D.G. Safran., "Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract," Health Affairs, Jan. 2011 30(1):51–61.

series of regular data and performance reports, ongoing consultative support from a team of clinicians and quality improvement advisors, and regular organized sessions where the groups meet together to address performance improvement issues and share best practices. Some information is provided to AQC groups daily – including information on patients who are in-hospital so as to allow the AQC to coordinate closely with the hospital and plan for the care that will be required when the patient is discharged. Performance information is provided monthly or quarterly through a series of reports allow groups to monitor their performance on the quality bonus measures, to monitor spending relative to their budget, and to evaluate opportunities for savings.

One unique set of reports that BCBSMA provides to assist AQC organizations with managing their use of overall resources is information on clinically-specific, unexplained practice pattern variations. The approach is rooted in the seminal work and compelling observations of Jack Wennberg and the Dartmouth Atlas – but importantly, moves the observations of practice pattern variation off of maps and into a framework that is clinically actionable for practicing physicians. The set of practice pattern variation analyses (PPVA) reports that BCBSMA provides includes: (1) condition-specific variations in treatment provided in a given medical or surgical specialty; and (2) potentially avoidable use of hospital resources (e.g., 30-day readmissions, non-urgent emergency department use, admissions for ambulatory sensitive conditions).

The condition-specific practice pattern variation analyses demonstrate how physicians within a given specialty (e.g., cardiology), differ from their peers in their use of particular treatments, tests or procedures for patients with the same underlying clinical status. The AQC groups receive analyses related to conditions such as: treatment of knee, back and hip pain; use of brand-name medications rather than generics, cardiac catheterization and coronary artery bypass graft (CABG) procedures; advanced imaging; non-urgent emergency room care; and treatment of gastroesophageal reflux disease (GERD).

BCBSMA's PPVA approach draws from a methodology developed by Dr. Howard Beckman (Rochester, NY) and successfully implemented through his work with Focused Medical Analytics' (FMA).[2] Dr. Beckman's work has demonstrated that, by comparing physicians' use of services to their local peers, and by addressing case mix concerns by narrowly defining the patient population of interest, individual physicians become quickly and meaningfully engaged in understanding and addressing differences in their tendency to use various treatments, tests and procedures compared with their peers. In beginning to use this approach in our network and the AQC groups in particular, BCBSMA's aim is to provoke important discussion among clinicians and leaders within each specialty, and ultimately, to stimulate the development of best practices and standards of care from within the profession. Such a process is preferable to one of externally imposed standards that might never be fully accepted by clinicians or patients.

**AQC: The Results**

First-year results show the AQC is on track achieve its original goals of improving patient care and moderating health care costs. In year-1 of the contract, all AQC groups met their budgets, and achieved a surplus. On the quality side, the AQC groups' first year improvements in the quality of

[2] RA Greene, HB Beckman, T Mahoney, "Beyond The Efficiency Index: Finding A Better Way To Reduce Overuse And Increase Efficiency In Physician Care," *Health Affairs*, 27, no. 4 (2008): w250-w25.9

patient care were greater than any one-year change seen previously in our provider network – well exceeding both the rates of improvement on quality measures that AQC groups were achieving prior to the contract, and exceeding rates of improvement among non-AQC physicians.

As previously mentioned, it is important to note that despite the fact that the AQC groups vary with respect to geography, size, management structure and experience with taking on risk for patient care, each and every AQC organization was successful in managing the global budget and significantly improving quality and clinical outcomes. The range of organizational models in the AQC includes multi-specialty integrated groups, independent practice associations, and several physician-hospital organizations, in which a physician group contracts with a particular hospital. Although all AQC physicians are part of some organizational structure that contracts on their behalf, about twelve percent of participating physicians are in one- or two-physician practices and one-third are in practices with fewer than five physicians. For these more distributed practices, qualitative feedback indicates that the role of the organizational leadership has been critical to their success. In fact, some of the most significant quality improvements come from the more loosely-affiliated, smaller provider organizations in the AQC.

***Improving Quality and Outcomes***

The first year quality results demonstrate that the AQC is changing the delivery of care across the system and improving patient care overall. As stated earlier, BCBSMA's set of AQC performance measures include both ambulatory and hospital quality indicators.

*Ambulatory Performance: Clinical Process Measures***.** On the ambulatory care side, within the BCBSMA network, physicians that are part of an AQC group performed much better than those outside of an AQC arrangement on important measures of preventive care, like cancer screenings and well-baby care, as well as measures of chronic disease care. With respect to preventive care, the rate of improvement in AQC groups' performance on certain process of care measures was *three times* that of non-AQC physicians — and more than twice the AQC groups' own improvement rates prior to the contract.

Process measures assess the appropriate use of tests or procedures in accordance with clinical guidelines. For chronic diseases such as diabetes and cardiovascular disease, among the most costly and prevalent chronic care conditions, the AQC groups' rate of improvement on screening and monitoring measures far exceeded those of physicians not in an AQC contract. In year one of the contract, AQC organizations made gains on these measures at a rate *more than four-times* what they had been accomplishing before the contract. Importantly, AQC physicians serving a large segment of socio-economically disadvantaged patients were equally successful as those serving more advantaged groups with respect to achieving high levels of performance in both preventive and chronic care quality.

*Ambulatory Performance: Clinical Outcome Measures.* AQC groups also achieved extremely high performance on ambulatory outcome measures — that is, effectively managing a patient's chronic conditions to ensure that he or she is stable. In fact, for several of the clinical outcome measures, performance among AQC groups reached or approached the highest levels of quality believed to be attainable for a patient population. Outcome measures are clinical results, such as control of blood pressure, blood sugar, or cholesterol, which indicate that a patient's chronic condition like diabetes or cardiovascular disease is well-managed. Achieving high performance on these

measures requires physicians to engage with patients in a way that extends well beyond the bounds of the office visit. This is because success on these measures requires patients to both understand and be diligent about managing their condition on a day-to-day basis – including ongoing attention to dietary restrictions, medication use, and physical activity. Year one results on these clinical outcome measures demonstrate that the AQC physicians are indeed rising to the challenge of accountability for these results that occur *after* the patient leaves the office visit.

*Hospital Performance*: On the hospital side, the AQC groups made significant improvements on hospital quality in year-one, including improvements on a broad set of clinical quality and patient experience measures. Hospitals contracted as part of an AQC arrangement ended year-1 with significantly better results on inpatient clinical outcomes, including fewer infections and complications, and made significantly greater gains in patient care experience measures than non-AQC hospitals. All hospitals in our network participate in a program called Hospital Performance Incentive Program (HPIP), which offers hospitals financial rewards for performance on a set of measures nearly identical to those used in the AQC.

***Moderating Health Care Spending***

Year-1 results find the AQC on track to achieve its original goal of reducing annual health care cost trends by one-half over the five years of the AQC contracts while continuously improving quality. All AQC groups met their year-1 budgets, and achieved surpluses that enabled them to invest in important infrastructure and staffing improvements, such as care managers and electronic data sharing between physicians and the hospital. Infrastructure investments will help provider organizations deliver care more effectively and efficiently.

For the most part, the early savings relative to budgets were achieved through AQC providers addressing the price rather than the quantity of services received by their patients. That is, using information provided through the BCBSMA support program, AQC providers were able to identify less costly care settings for elements of care such as lab tests, imaging and routine procedures. By managing referrals for these types of commodity services to lower cost, convenient settings, AQC providers achieved significant savings without impinging on or disrupting existing patient care relationships. In other cases, AQC providers made concerted efforts to establish new relationships with lower cost, high quality hospitals and to begin moving business accordingly. The *Boston Globe* reported on a number of these newly forged relationships, wherein AQC providers began moving business from one Boston-based academic medical center to another – based both on the cost and quality of care at the AMCs.

To a more limited extent in year-1, AQC organizations began the more complex and challenging work of identifying and reducing clinically wasteful care. For example, one AQC group reduced non-urgent use of the emergency room by 22 percent in year-1, which translated into $300,000 in avoided ER costs. Two of the more mature AQC organizations, were able to significantly reduce hospital readmissions, saving $1.8 million in avoided hospital costs. Efforts to address overall utilization, identifying and reducing clinically wasteful care, are continuing and maturing over the course of the 5-year contracts.

**AQC: The Future**

The AQC first year results offer promise that provider organizations – given the right incentives, information, data and leadership – can quickly accomplish significant improvements in patient care and outcomes while at the same time reducing the growth in health care costs. Going forward, BCBSMA will continue to develop, expand and refine the AQC model, as well as:

- Work with AQC providers who would like to be part of Medicare and/or Medicaid payment reform demonstrations under a similar global budget model with quality incentives
- Align member incentives through new product and benefit design
- Pilot the expansion of AQC into PPO using either an attribution-based method or a "physician of choice" model (or both) as the means of identifying members' primary physician

In 2011, BCBSMA made some revisions to the original AQC model, taking into account key lessons learned from our experiences with the initial cohort of AQC groups. The two main revisions are as follows:

(1) In 2011 and 2012 contracts, annual inflation targets over the 5 year contract period will be tied to regional network average trends, rather than set in absolute (fixed percentage) terms. This change will obviate the need for some of the protections for environmental and/or market effects that have been necessary to include with the original model's fixed percentage trend targets. With targets tied to the regional network trend, these environmental factors will already be accounted for and thus, will not require ongoing adjustments over the course of the contract that added unintended complexity to the original model.

(2) Beginning with 2011 and 2012 contracts, the AQC model establishes a link between performance on quality and the AQC provider's share of surplus or deficit. Higher quality scores translate into a higher share of surplus retained by an AQC provider who achieves savings relative to their budget; and translate into a lower share of deficit borne by an AQC provider who overspends their budget. In this way, regardless of whether an AQC organization is running a surplus or deficit relative to their budget, they have a strong incentive to strive for the highest possible performance on the quality measures.

As the model evolves and expands, the AQC will lead to long-term sustainability of the health care delivery system and improved patient care and health. BCBSMA is committed to working with clinician and hospital partners to make the AQC model work for all types of health-care delivery systems.

For federal and state policymakers, the findings from the first year of the AQC hold several important lessons. Among these is evidence that a payment model that creates provider accountability for both medical spending and health care quality and outcomes appears to be a

powerful vehicle for realizing the goal of a high performance health care system with a sustainable rate of spending growth. Additionally, the demonstrated success of provider organizations that varied widely in size, scope, and composition – some with a hospital, others without; most comprised of many small and solo practices united through a common leadership – is encouraging and should inform delivery system reform efforts nationally. Multi-year contracts based on a global budget, with annual inflation rates that are set at the outset of the agreement can bring important and welcome predictability to health care costs for employers, the public and others purchasing care. Finally, payment models that liberate providers from many of the constraints of fee-for-service payment, and importantly, from a mindset that one only does for patients those things for which there is a billing code, are almost certainly necessary and fundamental to making real the vision of safe, affordable, effective, patient-centered care.

On behalf of Andrew Dreyfus, President & CEO of Blue Cross Blue Shield of Massachusetts and all of my colleagues, we look forward to working with the you as you address the important issues of delivery system reform. Thank you again for the opportunity to testify. I look forward to any questions you may have.